Dual Diagnosis Capability in Addiction Treatment (DDCAT) Pilot Project: Final Report

FY 2007-2009

California Department of Alcohol and Drug Programs
Co-Occurring Disorders Unit
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Department of Alcohol and Drug Programs

Program Services Division

Co-Occurring Disorders Unit

Dual Diagnosis Capability in Addiction Treatment

Pilot Project

Final Report

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I. THE DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT INDEX

The Dual Diagnosis Capability in Addiction Treatment Index (DDCAT) is a fidelity index used to assess the capability of addiction treatment programs to treat clients with co-occurring disorders (COD). The terms Dual Diagnosis and Co-Occurring Disorders describe the same phenomena, the presence in one person of at least one substance use (abuse or dependence) disorder and at least one mental disorder. For the purposes of this report the terms dual diagnosis and COD are considered to be interchangeable.

With funding and other assistance from the Robert Wood Johnson Foundation and the SAMHSA Co-Occurring State Incentive Grant (COSIG) program, Mark P. McGovern, Ph. D., and others at the Dartmouth Medical School, Department of Psychiatry, in Lebanon, New Hampshire developed the DDCAT. Since its first iteration in 2003, the tool has seen refinements but no major changes in its format, scoring system, or definitions of standards. The DDCAT has been placed in the public domain and is available for download from the internet (at http://dms.dartmouth.edu/prc/dual/atsr/) without charge to anyone who wishes to use it.

The DDCAT (see Appendix A) ranks seven scales (or dimensions) and thirty-five benchmarks to assess overall performance. A DDCAT survey determines at what level an addiction treatment program is capable of providing COD services. The DDCAT process provides programs with methods in which their services, and thus their ranking can be improved. An action plan process is included (see Appendix B), should the provider decide to seek to become more capable at providing COD services.

The DDCAT is now a nationally recognized assessment tool and is recommended by the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

II. THE PURPOSE OF THE DDCAT PILOT PROJECT

In 2006 the DDCAT came to the attention of the Co-Occurring Joint Action Council (COJAC) – an advisory body to the Directors of the Department of Alcohol and Drug Programs (ADP) and the Department of Mental Health (DMH). Dr. McGovern spoke to the COJAC membership via teleconference in early 2007. The COJAC workgroup suggested ADP further research the utility of the DDCAT in California.

Though there are no California regulatory or statutory requirements to provide publicly funded COD services to either alcohol and other drug (AOD) and mental health recovery and treatment populations. SAMHSA's initiation of the Co-Occurring Center for Excellence (COCE), shows federal interest in providing a support structure for COD treatment services. Acknowledging this interest and with the recommendation from COJAC, the Departments developed the DDCAT Pilot.

III. PREPARATION FOR THE PILOT PROJECT

ADP and DMH approved the Pilot Project concept in the fall of 2007. ADP was able to move forward with the pilot project. The Pilot Project proposal included training program staff in the use of the DDCAT assessment tool, which required the development of a training curriculum and handouts for attendees. AOD treatment programs were notified of the training availability and current schedule of training times and facilities.

The major goals of the Pilot Project were both to investigate the usefulness of the DDCAT in California and to determine the willingness of AOD providers in California to participate in the DDCAT process and undergo an outside assessment of their ability to treat clients with COD. These goals were fundamental for exploring the utility of the tool in assessing the ability of State-licensed AOD treatment programs to treat clients with COD.

Additionally, the Pilot sought to determine the importance of DDCAT training in order for providers to be able to use the tool accurately.

Further benefits of the Pilot Project included the collection of State data on COD treatment capability, the sharing of information about COD and the DDCAT, and the dissemination of training and technical assistance to programs. DDCAT Pilot Project preparation proceeded through the stages below:

A. Independent Trainer / Surveyor

The DDCAT assessment trainer/surveyor was both a Registered Nurse licensed for more than 30 years by the State of California and a Psychiatric Nurse certified for 25 years by the American Nursing Association. She had been employed in a COD treatment program during a portion of the 13 years she worked at a DMH facility.

B. Developing a training program

The trainer/surveyor developed the training program from the training manual for the DDCAT and with input from the COD Unit.

C. Setting the parameters

The Pilot Project used the current iteration of the DDCAT, Version 3.2. This version consists of a cover sheet that doubles as a scoring sheet, a nine-page rating scale grid and a forty-page instruction manual. Copies of this material were provided to each participant. The procedure for the DDCAT Pilot Project included two DDCAT assessments, one done by the facility's staff, the other done by an independent assessor.

The trainer/surveyor created a technical resource binder that was offered to participating programs throughout the Pilot Project. The binder contained information on training, survey structure and schedule, technical advisory board telephone numbers, DDCAT tool, scoring sheet, Action Plan, worksheets, etc.

IV. RECRUITING VOLUNTEER PROGRAMS

ADP announced it was doing a pilot project testing the DDCAT at a COJAC Workgroup meeting. The response from the Workgroup members was positive and enthusiastic. Three of the first year's four surveyed programs came from the facilities run by COJAC members. The fourth slot for the first year was filled by a facility in Sacramento that had worked with the Department in the past. There was no problem filling the volunteer program slots available. The second year the Department recruited programs from residential perinatal programs licensed and certified by the Department. All available slots filled quickly.

V. TRAINING PERSONNEL FROM THE VOLUNTEER PROGRAMS

The Pilot Project included a component of DDCAT training for participating program staff. This training served to provide a consistent basis for the DDCAT self assessments required by the Pilot Project. Additionally, the responses to the evaluation forms for the trainings provided the information necessary to evaluate the importance of such training for treatment providers' usage of the DDCAT.

VI. PROGRAM SELF ASSESSMENT

An integral part of the DDCAT process is the program self assessment survey where the program staff review their own programs through the use of the DDCAT Index. All programs found areas where they could improve. Only one program accepted into the Pilot Project failed to generate that survey. That program was subsequently dropped from the Pilot Project for failure to meet required responsibilities.

VII. ADP ASSESSOR VALIDATION ASSESSMENTS

After each program completed its self assessment, the ADP Surveyor performed an independent validation survey. The same tools and information were used. All programs willingly cooperated with the ADP Surveyor. This validation survey is also part of the standard DDCAT process. The DDCAT assessment levels are: Addiction Only Services (AOS), Dual Diagnosis Capable (DDC) services, and Dual Diagnosis Enhanced (DDE) services.

VIII. FINDINGS

At the end of the Pilot Project, 21 pairs of DDCAT surveys were completed. This included the trainer/assessor's independent validation surveys of the 21 program self-assessments using the DDCAT tool. All surveys were done onsite at the programs.

The number of facilities offering "dual diagnosis capable" (DDC) was slightly less than half of the total number of facilities surveyed: 48%. Approximately 38% of the programs scored at the lower "addiction only services" (AOS) level; Approximately 14% achieved the top "dual diagnosis enhanced' (DDE) status.

The results indicated a wide range of capability for the treatment of clients with COD in California. That nearly half of the programs (10 of 21) were ranked DDC and three were ranked DDE suggests that many programs in California are aware of the need for services for clients with COD and are working toward providing such services.

IX. CONCLUSION

SAMHSA's data on prevalence shows that there is a large unaddressed need for COD services within the United States. As public understanding of the need for COD treatment grows there will almost certainly be initiatives to further address program design, funding and oversight for COD treatment providers in order to assure access to appropriate care. As these changes occur, either as part of national health care reform or independently promoted by individual states, the need for a tool that evaluates the capabilities of a program to provide services for people with COD is essential. The Pilot Program has shown that the DDCAT is an appropriate tool in California and that the providers and program staff are capable of useful DDCAT self-assessment and willing to have their programs assessed. In fact many were enthusiastic about their participation and about ADP looking to the future and investigating this process.

The participating treatment facilities commented with regularity on the difficulty of developing COD programs. This difficulty is not because of the treatment needs of the clients. Instead, the comments addressed problems with the various mental health and AOD treatment funding stream, work force, oversight, and accountability elements that operate independently of, and at times contrary to, one another. This lack of consistency creates challenges that exceed the administrative and resource capacity and capability of most community providers. As a result, the DDCAT scores of the California Pilot Project reflect somewhat lower scores than other regions of the country where the two behavioral health systems have greater integration. Appendix D lists the scores of these surveys.

APPENDIX A – DDCAT Tool

DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT INDEX
RATING SCALE COVER SHEET

Program Identification
Date: _____ **Rater(s):** _____ **Time Spent (Hours):** _____

Agency Name: _____

Program Name: _____

Address: _____ **Zip Code:** _____

Contact Person: 1) _____**; 2)** _____

Telephone: _____**; FAX:** _____**; Email:** _____

State: _____ **Region:** _____ **Program ID:** _____ **Time Period:** ____ **(1= Baseline; 2 = 1st-follow-up; 3= 2nd follow-up; 4= 4th follow-up; etc)**

Program Characteristics

Payments received (program):
_____ Self-pay
_____ Private health insurance
_____ Medicaid
_____ Medicare
_____ State financed insurance
_____ Military insurance

Other funding sources:
_____ Other public funds
_____ Other funds

Primary focus of agency:
_____ Addiction treatment services
_____ Mental health services
_____ Mix of addiction & MH services
_____ General health services
_____ Hospital

Size of Program:
_____ # of admissions/last fiscal year
_____ Capacity (highest # servable)
_____ Average length of stay (in days)
_____ Planned length of stay (in days)
_____ # of unduplicated clients/year

Agency type:
_____ Private
_____ Public
_____ Non-Profit
_____ For-Profit
_____ Government operated
_____ Veterans Health Admin

Level of care:
ASAM-PPC-2R (Addiction):
_____ I. Outpatient
_____ II. IOP/Partial Hospital
_____ III. Residential/Inpatient
_____ IV. Medically Managed Intensive Inpatient (Hospital)
_____ OMT: Opioid Maintenance
_____ D: Detoxification
Mental Health:
_____ Outpatient
_____ Partial hospital/Day program
_____ Inpatient

Exclusive program/Admission criteria requirement:
_____ Adolescents
_____ Co-occurring MH & SUD disorders
_____ HIV/AIDS
_____ Gay & Lesbian
_____ Seniors/Elders
_____ Pregnant/post-partum
_____ Women
_____ Residential setting for patients & their children
_____ Men
_____ DUI/DWI
_____ Criminal justice clients
_____ Adult General

DDCAT assessment sources _____ Chart Review: _____ Agency brochure review: _____ Program manual review; _____ Team meeting observation; _____ Supervision observation: _____ Observe group/individual session: _____ Interview with Program Director: _____ Interview with Clinicians: _____ Interview with clients (#: ____); _____ Interview with other service providers; _____ Site tour.

Total # of sources used: _____

DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT (DDCAT) *VERSION 3.2*
RATING SCALE

	1 AOS	2	3 DDC	4	5 DDE
I. PROGRAM STRUCTURE					
IA. Primary focus of agency as stated in the mission statement (If program has mission, consider program mission)	Addiction Only		Primary focus is addiction, co-occurring disorders are treated		Primary focus on persons with co-occurring disorders.
IB. Organizational certification & licensure.	Permits only addiction treatment	Has no actual barrier, but staff report there to be certification or licensure barriers.	Has no barrier to providing mental health treatment or treating co-occurring disorders within the context of addiction treatment		Is certified and/or licensed to provide both
IC. Coordination and collaboration with mental health services.	No document of formal coordination or collaboration. Meets the SAMHSA definition of minimal Coordination.	Vague, undocumented, or informal relationship with MH agencies, or consulting with a staff member from that agency. Meets the SAMHSA definition of Consultation.	Formalized and documented coordination or collaboration with mental health agency. Meets the SAMHSA definition of Collaboration.	Formalized coordination & collaboration, and the availability of case management staff, or staff exchange programs (variably used) Meets the SAMHSA definition of Collaboration and has some informal components consistent with Integration.	Most services are integrated within the existing program, or routine use of case management staff or staff exchange programs. Meets the SAMHSA definition of Integration.
ID. Financial incentives.	Can only bill for addiction treatments or for persons with substance use disorders.	Could bill for either service type if substance use disorder is primary, but staff report there to be barriers. –OR- Partial reimbursement for MH services available	Can bill for either service type, however, substance use disorder must be primary.		Can bill for addiction or mental health treatments, or the combination and/or integration.
	1	**2**	**3**	**4**	**5**

II. PROGRAM MILIEU	**AOS**		**DDC**		**DDE**
IIA. Routine expectation of and welcome to treatment for both disorders	Expects substance use disorders only, refer or deflect persons with mental health disorders or symptoms.	Documented to expect substance use disorders only (e.g. admission criteria, target population), but have informal procedure to allow some persons with mental health problems to be admitted.	Expect substance use disorders, and, with documentation, accepts mental health disorders by routine and if mild and relatively stable.	Program formally defined like DDC but clinicians and program informally expects and treats both disorders, not well documented.	Clinicians and program expect and treat both disorders, well documented.
IIB. Display and distribution of literature and patient educational materials.	Addiction or peer support (e.g. AA) only	Available for both disorders but not routinely offered or formally available.	Available for both mental health & substance use disorders, but distribution is less for mental health problems.	Available for both mental health & substance use disorders with equivalent distribution.	Available for the interaction between both mental health and substance use disorders.
	1	**2**	**3**	**4**	**5**

III. CLINICAL PROCESS: ASSESSMENT	AOS		DDC		DDE
IIIA. Routine screening methods for psychiatric symptoms	Pre-admission screening based on patient self-report. Decision based on clinician inference from patient presentation or by history.	Pre-admission screening for symptom & treatment history, current medications, suicide/homicide history prior to admission.	Routine set of standard interview questions for MH using generic framework, e.g. ASAMPPC (Dimension III) or Bio-psychosocial data collection.	Screen for mental health problems using standardized or formal instruments with established psychometric properties.	Standardized or formal instruments for both mental health and substance use disorders with established psychometric properties.
IIIB. Routine assessment if screened positive for psychiatric symptoms	Ongoing monitoring for appropriateness or exclusion from program	More detailed Bio-psychosocial assessment, mental status exam, each clinician driven	Formal mental health assessment, if necessary, typically occurs.	Increased capacity to access follow-up mental health assessments, although not standardized or routine.	Standardized or formal integrated assessment is routine in all cases.
IIIC. Psychiatric and substance use diagnoses made and documented.	Psychiatric diagnoses are not made or recorded	Mental health diagnostic impressions made and recorded variably.	Mental health diagnosis variably recorded in chart.	Mental health diagnosis more frequently recorded but inconsistently	Standard & routine mental health diagnoses consistently made.
IIID. Psychiatric and substance use history reflected in medical record.	Collection of substance use disorder history only.	Standard form collects substance use disorder history only. Mental health history collected inconsistently.	Routine documentation of both mental health and substance use disorder history in record in narrative section.	Specific section in recorded dedicated to history and chronology of course of both disorders.	Specific section in record devoted to history and chronology of course of both disorders and the interaction between them is examined temporally.
IIIE. Program acceptance based on psychiatric symptom acuity: low, moderate, high.	Admits persons with no to low acuity.		Admits persons in program with low to moderate acuity, but who are primarily stable.		Admits persons in program with moderate to high acuity, including those unstable in their psychiatric condition.
IIIF. Program acceptance based on severity of persistence and disability: low, moderate, high.	Admits persons in program with no to low severity of persistence of disability		Admits persons in program with low to moderate severity.		Admits persons in program with moderate to high severity
IIIG. Stage-wise assessment	Not assessed or documented.	Assessed & documented variably by individual clinician	Clinician assessed and routinely documented, focused on substance use disorders motivation	Formal measure used and routinely documented but focusing on substance use disorders motivation only.	Formal measure used and routinely documented, focus on both substance use and mental health motivation.
	1	2	3	4	5

IV. CLINICAL PROCESS: TREATMENT	AOS		DDC		DDE
IVA. Treatment plans.	Address addiction only (Mental health not listed)	Variable by individual clinician	Substance use disorders addressed as primary, mental health as secondary	Systematic focus is available but variably used.	Address both as primary, both listed in plan consistently.
IVB. Assess and monitor interactive courses of both disorders.	No attention or documentation of progress with mental health problems	Variable reports of progress on mental health problems by individual clinicians.	Clinical focus in narrative (treatment plan or progress note) on mental health problem change	Systematic focus is available but variably used.	Clear, detailed, and systematic focus on change in both substance use and mental health disorders.
IVC. Procedures for psychiatric emergencies and crisis management.	No guidelines conveyed in any manner.	Verbally conveyed in-house guidelines.	Documented guidelines: Referral or collaborations (to local mental health agency or E/R)		Routine capability, or a process to ascertain risk with ongoing use of substances. Maintain in program unless commitment is warranted
IVD. Stage-wise treatment	Not assessed or explicit in treatment plan.	Stage or motivation documented variably by individual clinician in treatment plan.	Stage or motivation routinely incorporated into individualized plan, but no specific stage-wise treatments.	Stage or motivation routinely incorporated into individualized plan, and general awareness of adjusting treatments by individual stage of readiness on substance use motivation only.	Stage or motivation routinely incorporated into individualized plan, and formally prescribed and delivered stage-wise treatments for both substance use and mental health issues.
IVE. Policies and procedures for medication evaluation, management, monitoring and compliance.	Patients on meds routinely not accepted. No capacities to monitor, guide or provide psychotropic medications during treatment.	Certain types of meds are not acceptable. Or must have own supply for entire treatment episode. Some capacity to monitor psychotropic medications.	Present, coordinated medication policies. Some access to prescriber for psychotropic medications and policies to guide the prescribing within the program is provided. Monitoring of the medication is largely provided by the prescriber.	Clear standards and routine for medicating provider who is also a staff member. Regular access to prescriber and guidelines for prescribing in place. The prescriber might more regularly consult with other staff regarding medication plan and recruit other staff to assist with medication monitoring	Clear standards and routine for medicating provider who is also a staff member and present on treatment teams or administration. Full access to prescriber with appropriate prescribing guidelines in place. As a treatment team member, the prescriber informs the team about the medication plan and the entire team can assist with monitoring.
	1	2	3	4	5

IV. CLINICAL PROCESS TREATMENT (cont)	AOS		DDC		DDE
IVF. Specialized interventions with mental health content.	Not addressed in program content	Based on judgment by individual clinician; Irregular penetration into routine services	In program format as generalized intervention, e.g. stress management); More regular penetration into routine services. Routine clinician adaptation of an evidence-based addiction treatment (e.g. MI, CBT, TSF)	Some specialized interventions by specifically trained clinicians in addition to routine generalized interventions.	Routine MH symptom management groups; Individual therapies focused on specific disorders; Systematic adaptation of an evidence-based addiction treatment (e.g. MI, CBT, TSF).
IVG. Education about psychiatric disorder & its treatment, and inter-action with substance use & its treatment.	No	Variably	Variably Present in generic format and content, and delivered in individual and/or group formats.		Present specific content for specific disorder co-morbidities, and delivered in individual and/or group formats.
IVH. Family education and support.	For alcohol or drug problems only	Variably or by individual clinical judgment	MH issues regularly but informally incorporated into family education or support sessions. Available as needed.	Generic group on site for families on substance use and mental issues, variably offered. Structured group with more routine accessibility	Routine and systematic co-occurring disorder family group integrated into standard program format. Accessed by the majority of families with co-occurring disorder family member
IVI. Specialized interventions to facilitate use of peer support groups in planning or during treatment.	None used to facilitate either use of addiction or mental health peer support	Used variably by or infrequently by individual clinicians, for individual patients, mostly for facilitation of addiction peer support groups	Present, generic format on site, but no specific or intentional facilitation based on mental health problems. More routine facilitation of traditional addiction peer support groups (e.g. AA, NA)	Present but variable facilitation to peer support groups targeting specific mental health issues, either to traditional peer support groups or those specific to both (e.g. DRA, DTR, etc).	Routine & specific to need of co-occurring persons, special programs on site, routinely targeted to specific issues, either to traditional peer support groups or those specific to both (e.g. DRA).
IVJ. Availability of peer recovery supports for patients with CODs.	Off site, recommended variably	Present, off site and facilitated with contact persons or informal matching with peer supports in the community, some co-occurring focus.	Present, off site and facilitated with contact persons or informal matching with peer supports in the community, some co-occurring focus.	Present, off site, integrated into plan, and routinely documented with co-occurring focus.	Present, on site, facilitated and integrated into program (e.g. alumni groups); Routinely used and documented with co-occurring focus.
	1	2	3	4	5

V. CONTINUITY OF CARE	AOS		DDC		DDE
VA. Co-occurring disorder addressed in discharge planning process.	Not addressed.	Variably addressed by individual clinicians.	Co-occurring disorder systematically addressed as secondary in planning process for off site referral.		Both disorders seen as primary, and plans made and insured, on site, or by arrangement - off site, at least 80% of the time.
VB. Capacity to maintain treatment continuity.	No mechanism for managing ongoing care of mental health needs when addiction treatment program is completed.	No formal protocol to manage mental health needs once program is completed, but some individual clinicians may provide extended care until appropriate linkage takes place; Variable documentation	No formal protocol to manage mental health needs once program is completed, but when indicated, most individual clinicians provide extended care until appropriate linkage takes place; Routine documentation	Formal protocol to manage mental health needs indefinitely, but variable documented evidence that this is routinely practiced, typically within the same program or agency.	Formal protocol to manage mental health needs indefinitely and consistent documented evidence that this is routinely practiced, typically within the same program or agency.
VC. Focus on ongoing recovery issues for both disorders.	No	Individual clinician determined.	Routine focus is on recovery from addiction, mental health issues are viewed as potential relapse issues only.		Routine focus on addiction recovery and mental health illness management and recovery, both seen as primary and ongoing.
VD. Facilitation of peer support groups for co-occurring disorders is documented and a focus in discharge planning, and connections are insured to community peer recovery support groups.	No	Rarely, but addressed by individual clinicians	Yes, variable, but not routine or systematic, focus on co-occurring disorders peer support community connection (engagement in meetings or functions off-site)		Yes, routine and systematic, at least 80% of the time with focus on co-occurring disorders peer support community connection (engagement in meetings or functions off-site).
VE. Sufficient supply and compliance plan for medications is documented.	No medications in plan.		Yes, 30-day or supply to next appointment offsite		Maintains medication management in program with provider.
	1	2	3	4	5

VI. STAFFING	AOS		DDC		DDE
VIA. Psychiatrist or other physician or prescriber of psychotropic medications.	No formal relationship with a prescriber for this program.	Consultant or contractor off site.	Consultant or contractor on site.	Staff member, present on site for clinical matters only	Staff member, present on site for clinical, supervision, treatment team, and/or administration.
VIB. On site clinical staff members with mental health licensure (doctoral or masters level), or competency.	No formal relationship with program.	1-24% of clinical staff members.	25-33% of clinical staff members.	34-49% of clinical staff members.	50% or more of clinical staff members.
VIC. Access to mental health supervision or consultation.	Informal process.	Yes, on site supervision.	Provided regularly.	Yes, on site supervision. Provided regularly. Irregular documentation.	Yes, on site, documented regular supervision sessions for clinical matters.
VID. Case review, staffing or utilization review procedures emphasize and support co-occurring disorder treatment.	No	Variable, by off site consultant, undocumented.	Yes, on site, documented as needed (PRN) and with co-occurring disorder issues.		Yes. Documented, routine and systematic coverage of co-occurring issues.
VIE. Peer/Alumni supports are available with co-occurring disorders.	No		Present, but as part of community, and routinely available to program patients, either thru informal relationships or more formal connections such as thru peer support service groups (e.g. AA hospital and institutional committees; NAMI).		Present, on site, either as paid staff, volunteers, or routinely available program "alumni".
	1	2	3	4	5

VII. TRAINING	AOS		DDC		DDE
VIIA. Direct care staff members have basic training in prevalence, common signs & symptoms, screening and assessment for psychiatric symptoms and disorders.	Not trained in basic skills.	Variably trained, not documented as part of systematic training plan, but encouraged by management.	Trained in basic skills per agency strategic training plan.	Trained in these skills per agency strategic training plan, and also have some advanced training in specialized treatment approaches.	Trained in these skills per agency strategic training plan, and also have staff with advanced training in specialized treatment approaches as part of plan.
VIIB. Direct care staff members are crosstrained in mental health and substance use disorders, including pharmacotherapies, and have advanced specialized training in treatment of persons with co-occurring disorders.	Not trained, or not documented.	At least 33% trained.	At least 50% trained	At least 75% are trained	At least 90% are trained.
	1	2	3	4	5

ADDITIONAL SITE VISIT NOTES:

DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT PROGRAMS (DDCAT) *VERSION 3.2*
SCORING SUMMARY

I. Program Structure

A. _____
B. _____
C. _____
D. _____

_____
Sum Total = _____
/4 = **SCORE** _____

II. Program Milieu

A. _____
B. _____

_____
Sum Total = _____
/2 = **SCORE** _____

III. Clinical Process: Assessment

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____

_____
Sum Total = _____
/7 = **SCORE** _____

IV. Clinical Process: Treatment

A. _____
B. _____
C. _____
D. _____
E. _____
F. _____
G. _____
H. _____
I. _____
J. _____

_____
Sum Total = _____
/10 = **SCORE** _____

DDCAT INDEX PROGRAM CATEGORY: SCALE METHOD

OVERALL SCORE (Sum of Scale Scores/7): _____

DUAL DIAGNOSIS CAPABILITY:

AOS (1 - 1.99)	_____
AOS/DDC (2 - 2.99)	_____
DDC (3 - 3.49)	_____
DDC/DDE (3.5 - 4.49)	_____
DDE (4.5 - 5.0)	_____

DDCAT INDEX PROGRAM CATEGORY: CRITERION METHOD

% CRITERIA MET FOR AOS (# of "1" scores/35):	**100%**
% CRITERIA MET FOR DDC (# of "3 or <" scores/35):	_____
% CRITERIA MET FOR DDE (# of "5" scores/35):	_____

HIGHEST LEVEL OF DD CAPABILITY (80% or more): _____

V. Continuity of Care

A. _____
B. _____
C. _____
D. _____
E. _____

_____
Sum Total = _____
/5 = **SCORE** _____

VI. Staffing

A. _____
B. _____
C. _____
D. _____
E. _____

_____
Sum Total = _____
/5 = **SCORE** _____

VII. Training

A. _____
B. _____

_____
Sum Total = _____
/2 = **SCORE** _____

APPENDIX B - An Example of an Integrated Service Agency Action Plan

Agency: _____

Date submitted: _____

Program_____

Contact Person_____Title_____

Action Plans:

1. Action Plans should be based on the seven domains of the DDCAT Assessment and your DDCAT Report
2. The Action Plan is an incremental process. The agency does not need to have goals for all 35 items or for each of the 7 domains. The action plan should be attainable and prioritized to the needs of the program.
3. Action plans are not limited to a set number of goals. (You may use, cut, paste, add/delete on the following pages.)
4. The DDCAT toolkit will help a program develop their action plan.
5. High priority goals can look to areas of very high need and/or areas where action can be taken quickly and effectively.
6. Welcoming and screening for people with co-occurring conditions should be considered high priority.
7. Action plans should be adopted and integrated into your agency service plan, organization plan or strategic plan.
8. Action Plans are due within 30 days of receiving your DDCAT program review and updated annually;

EXAMPLE

Goal Domain	DDCAT Item	Action Steps	Due Date	Responsible People	Current status/ Next steps
Program structure: Make program more co-occurring focused	I.A. Primary treatment focus on dual diagnosis as stated in mission statement	Review and update current Mission Statement in brochures, manuals, and literature	8/31/08	Executive Director, Board of Directors	In process—Review at board meeting 8/15/08

APPENDIX C – Federal COD Prevalence Data

Excerpted from
TREATMENT IMPROVEMENT PROTOCOL 42
Substance Abuse Treatment for Persons with Co-Occurring Disorders

The Availability of Prevalence and Other Data

Prevalence and other data on COD have established the scope and impact of the problem, and the need for appropriate treatment and services. Four key findings are borne out by prevalence and other available data, each of which is important in understanding the challenges of providing effective treatment to this population.

(1) COD are common in the general adult population, though many individuals with COD go untreated.

National surveys suggest COD are common in the adult population. For example, the National Survey on Drug Use and Health (NSDUH) reports that in 2002, 4 million adults met the criteria for both serious mental illness (SMI) and substance dependence and abuse. NSDUH information is based on a sample of 67,500 American civilians aged 12 or older in noninstitutionalized settings (Office of Applied Studies [OAS] 2003). The NSDUH defined SMI as having at some time during the past year a diagnosable mental, behavioral, or emotional disorder that met the criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV) (American Psychiatric Association 1994) and resulted in functional impairment that substantially interfered with or limited one or more major life activities. The NSDUH classification scheme was not diagnosis specific, but function specific. Results from the survey are highlighted below.

- SMI is highly correlated with substance dependence or abuse. Among adults with SMI in 2002, 23.2 percent were dependent on or abused alcohol or illicit drugs, while the rate among adults without SMI was only 8.2 percent. Among adults with substance dependence or abuse, 20.4 percent had SMI; the rate of SMI was 7 percent among adults who were not dependent on or abusing a substance.

- Among adults who used an illicit drug in the past year, 17.1 percent had SMI in that year, while the rate was 6.9 percent among adults who did not use an illicit drug. Conversely, among adults with SMI, 28.9 percent used an illicit drug in the past year while the rate was 12.7 percent among those without SMI (OAS 2003*b*).

- SMI was correlated with binge alcohol use (defined as drinking five or more drinks on the same occasion on at least one day in the past 30 days). Among adults with SMI, 28.8 percent were binge drinkers, while 23.9 percent of adults with no SMI were binge drinkers.

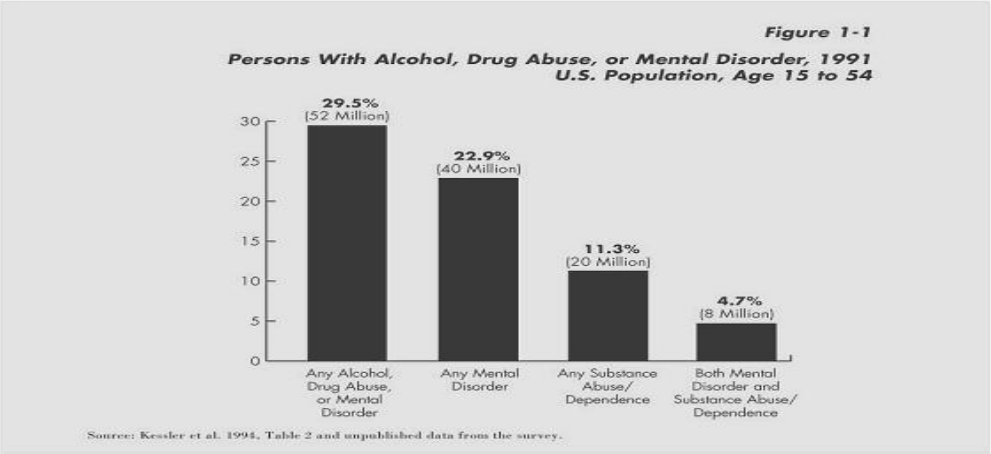


Figure 1-1. Persons With Alcohol, Drug Abuse, or Mental Disorder in the Past Year

Earlier, the National Comorbidity Study (NCS) reported 1991 information on mental disorders and substance abuse or dependence in a sample of 8,098 American civilians aged 15 to 54 in noninstitutionalized settings. Figure 1-1 shows estimates from the NCS of the comparative number of any alcohol, drug abuse, or mental disorder (52 million), any mental disorder (40 million), any substance abuse/dependence disorder (20 million), and both mental disorder and substance abuse/dependence (8 million) in the past year.

In a series of articles derived from the NCS, Kessler and colleagues give a range of estimates related to both the lifetime and 12-month prevalence of COD (Kessler et al. 1994, 1996*a*, *b*, 1997). They estimate that 10 million Americans of all ages and in both institutional and noninstitutional settings have COD in any given year. Kessler et al. also estimate the lifetime prevalence of COD (not shown in Figure 1-1), which relates only the prevalence in the past 12 months) (1996*a,* p. 25) as follows: "…51 percent of those with a lifetime addictive disorder also had a lifetime mental disorder, compared to 38 percent in the ECA." (The ECA—Epidemiologic Catchment Area study—predated the NCS study; this National Institute of Mental Health study of 20,291 people was representative of the total U.S. community and institutional populations [Regier et al. 1990]).

Comparative figures for individuals with COD whose addictive disorders involve alcohol versus drugs are also available. Fifty-three percent of the respondents with lifetime *alcohol* abuse or dependence also had one or more lifetime mental disorders. For respondents with lifetime *illicit drug* abuse/dependence, 59 percent also had a lifetime mental disorder, and 71 percent of those with lifetime illicit drug abuse/dependence had alcohol abuse or dependence over their lifetime (Office of the Inspector General 1995).

A recent first report from the National Comorbidity Survey Replication, conducted between February 2001 and December 2002 (Kessler and Walters 2002), provides more precise information on rates of specific disorders. For example, rates of major depressive disorder were reported at 6.6 percent in the general population in the last year, or an estimated number between 13.1 and 14.2 million people (Kessler et al. 2003*b*). Additional data from a new and expanded NCS survey are now available (e.g., Breslau et al. 2004*a*, *b*; Kessler 2003; Kessler et al. 2003*a*; see also the Web site www.hcp.med.harvard.edu/ncs).

Research suggests that the likelihood of seeking treatment is strongly increased in the presence of at least one co-occurring condition. The National Longitudinal Alcohol Epidemiologic Study (NLAES)—a nationwide household survey of 42,862 respondents aged 18 or older conducted by the National Institute on Alcohol Abuse and Alcoholism—reveals that a large increase in treatment for an alcohol disorder and a drug disorder occurs when there is a co-occurring "major depressive disorder" (Grant 1997). NCS data suggest that people with more than two disorders are more likely to receive treatment than those with "only" two. People with three or more diagnosable conditions were the most likely to be severely impaired and to require hospitalization (NAC 1997).

While people with co-occurring disorders are more likely to seek treatment, research consistently shows a gap between the number of people who are identified in a survey as having a disorder and the number of people receiving any type of treatment. Even of those with three or more disorders, a troubling 60 percent never received any treatment (Kessler et al. 1994; NAC 1997). Based on NLAES data, Grant (1997, p. 13) notes that one of the most interesting results of the survey is the "sheer number of respondents with alcohol and drug use disorders missing from the treated population. Only 9.9 percent and 8.8 percent of the respondents classified with past-year alcohol and drug use disorders, respectively, sought treatment."

(2) Some evidence supports an increased prevalence of people with COD and of more programs for people with COD.

NASADAD conducts voluntary surveys of State Alcohol and Drug Abuse Agencies and produces the State Alcohol and Drug Abuse Profile (SADAP) reports. In 1996, NASADAD asked the States to describe any special programs in their States for clients with COD and to provide any available fiscal year (FY) 1995 statistics on the number of "dually diagnosed" clients treated (Gustafson et al. 1997). Forty-one States plus Palau, Puerto Rico, and the U.S. Virgin Islands responded. About 3 years later, 31 States responded to a request for detailed statistics on the number of persons admitted in FYs 1996 and 1997 to programs for treatment of COD (Gustafson et al. 1999). In general, examination of SADAP State profiles for information related to COD suggests about a 10 percent increase since the NASADAD survey in both the number of people with COD entering treatment and in the number of programs in many States over that 3-year period (Gustafson et al. 1999).

The 2002 National Survey of Substance Abuse Treatment Services (N-SSATS) indicated that about 49 percent of 13,720 facilities nationwide reporting substance abuse services offered programs or groups for those with COD (OAS 2003*a*). However, only 38 percent of the 8,292 responding facilities that focused primarily on substance abuse offered such COD programming. Sixty-three percent of the 1,126 responding mental health services that offered substance abuse services offered COD programs or groups. About 70 percent of the 3,440 facilities that have a mix of mental health and substance abuse treatment services offer COD programs or groups.

Still it must be kept in mind that of all the approximately 1.36 million clients in treatment for substance use disorders in 2002, about 68 percent were treated in facilities whose primary focus was substance abuse services and 23 percent were treated in facilities whose focus was a mix of both mental health and substance abuse services. Only 4 percent of these

individuals were in facilities whose primary focus was the provision of mental health services.

(3) Rates of mental disorders increase as the number of substance use disorders increase, further complicating treatment.

In their analysis of data from a series of studies supported by the National Institute on Drug Abuse, the Drug Abuse Treatment Outcome Study (DATOS), Flynn et al. (1996) demonstrate that the likelihood of mental disorders rises with the increasing number of substance dependencies. Participating clients were assessed according to DSM-III-R criteria (*Diagnostic and Statistical Manual for Mental Disorders,* 3d edition revised) for lifetime antisocial personality, major depression, generalized anxiety disorder, and/or any combination of these disorders.

Figure 1-2

Rates of Antisocial Personality, Depression, and Anxiety Disorder by Drug Dependency (%). Taken From the Drug Abuse Treatment Outcome Study (DATOS)

Drug dependency	Antisocial personality	Major depression	Generalized anxiety
Alcohol only	34.7	17.8	5.5
Heroin only	27	7	2
Heroin and alcohol	46.3	13.2	3.2
Cocaine only	30.4	8.4	2.7
Cocaine and alcohol	47	13.6	4.7
Cocaine and heroin	44	10.8	2.2
Cocaine, heroin, and alcohol	59.8	17.1	6.3
Overall	39.3	11.7	3.7

Source: Flynn et al. 1996; data are from the NIDA-supported DATOS study.

Figure 1-2. Rates of Antisocial Personality, Depression, and Anxiety Disorder by Drug Dependency

DATOS was a national study of clients entering more than 90 substance abuse treatment programs in 11 metropolitan areas, mainly during 1992 (Flynn et al. 1997). Of the initial intake sample of 10,010 clients, 7,402 completed an intake and a clinical assessment interview and met DSM-III-R criteria for dependence on alcohol, cocaine, and/or heroin. shows a general trend of increase in the rates of DSM-III-R lifetime antisocial personality disorder, major depression, and generalized anxiety disorder as the number of substance dependencies involving alcohol, heroin, and cocaine increases (except for the relationship between alcohol dependence only and major depression and generalized anxiety). Since the use of multiple drugs is common in those with substance use disorders, treatment is further complicated for these people by the greater incidence of mental disorders that accompanies multiple drug use.

(4) Compared to people with mental or substance use disorders alone, people with COD are more likely to be hospitalized. Some evidence suggests that the rate of hospitalization for people with COD is increasing.

According to Coffey and colleagues, the rate of hospitalization for clients with both a mental and a substance use disorder was more than 20 times the rate for substance-abuse—only clients and five times the rate for mental-disorder—only clients (Coffey et al. 2001). This estimate is based on an analysis of the CSAT/Center for Mental Health Services (CMHS) Integrated Data Base Project, in which a team studied information from the mental health, substance abuse, and Medicaid agencies in Delaware, Oklahoma, and Washington. Using a broad coding for health policy research to study discharges between 1990-1995 from community hospitals nationwide, Duffy (2004, p. 45) estimated that clients classified as having both a substance-related disorder and a mental disorder significantly "…increased from 9.4 to 17.22 per 10,000 population…" with the 35–45 year age group increasing the most among the 7 age groups studied from childhood to 65 or older.

APPENDIX D: DATA FROM THE PILOT PROJECT

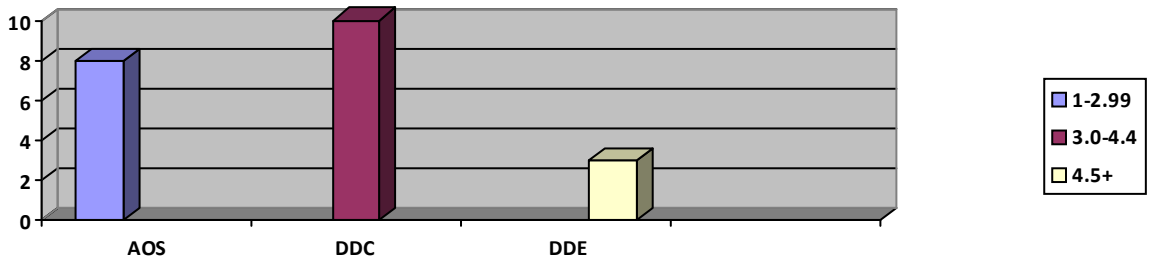
Assessment Survey Outcomes

A. Program Ratings

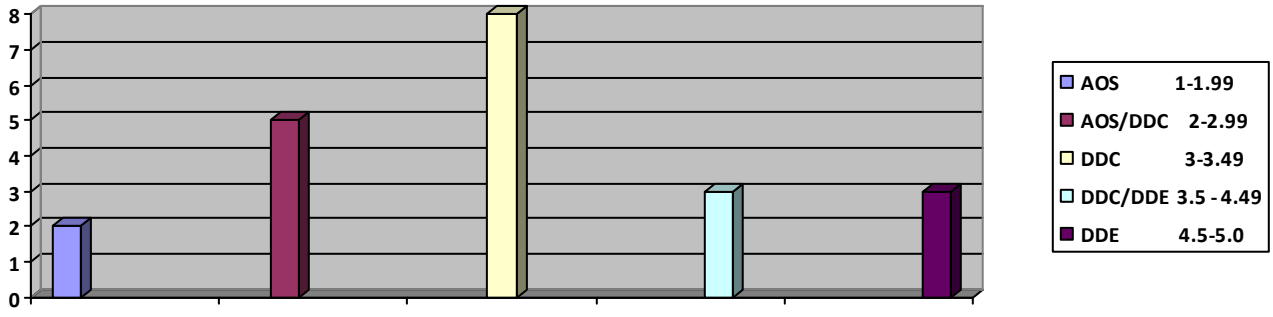
Twenty-one DDCAT surveys were completed and validated in the ADP Pilot Project. This included a comparison of program self-assessments using the DDCAT tool with the same program assessment completed by an ADP surveyor and yielded the following data;

The numbers of facilities offering "addiction only services (AOS)" were slightly less than half of the total number of facilities surveyed. The other programs were noted to be addressing "co-occurring disorder" treatment at some level. Thirty-eight percent of the programs were AOS and 48% were "dual diagnosis capable (DDC)". About 14% met dual diagnosis enhanced (DDE) status.

Rounded Results – Ratings of Pilot Facilities, Based on Scores



Unrounded Results – Ratings of Pilot Facilities, Based on Scores



B. Differences in DDCAT Scores

The table below depicts the differences in DDCAT scores between the initial self-assessment and the later independent assessment survey. The improved scores in some areas suggest that many facilities used the information they gathered during their self-assessment to make changes to incorporate DDCAT-modeled COD diagnoses and treatment components into their substance use treatment programs.

Comparison of Program DDCAT Self-Assessments vs. ADP surveyor findings

Level	Program Score	ADP Score	Variance
DDE	3.7	4.6	+0.9
DDE	4.8	4.5	-0.3
DDE	4.2	4.5	-0.3
DDC	4.1	3.5	+0.3
DDC	3.1	3.6	+0.5
DDC	3.2	3.1	-0.1
DDC	3.24	3.3	+0.06
DDC	2.8	3.2	+0.4
DDC	3.97	3.2	-0.7
DDC	3.1	3.26	+0.16
DDC	3.6	4.1	+0.5
DDC	2.6	3.4	+0.8
DDC	2.2	3.3	+1.1
AOS	2.92	2.4	-0.5
AOS	2.8	2.4	-0.5
AOS	2.8	1.8	-1.0
AOS	2.4	2.8	+0.4
AOS	2.8	2.0	-0.8
AOS	2.8	2.57	-0.23
AOS	2.2	2.9	+0.7
AOS	2.9	2.4	-0.5
AOS	1.5	1.6	+0.1
TOTAL	**64.9 / 21= 3.09 average**	**68.03 / 21= 3.24 average**	**0.24 average variance**

Differences, Facility Rankings and ADP Rankings